

Pre-Op History and Physical Exam

Patient's Name: _____ DOB: _____
 Home Phone: (____) _____ Cell: (____) _____
 Attending Physician: _____ Today's Date: _____
 Planned Procedure: _____ Procedure Date: _____
 PCP: _____ Phone: (____) _____

HISTORY OF PRESENT ILLNESS: _____

MEDICAL HISTORY: _____

SURGICAL HISTORY: _____

SLEEP APNEA: Yes No **CPAP prescribed:** Yes No **Compliant:** Yes No

SOCIAL HISTORY: Smoking: _____ ETOH: _____ Other: _____

MEDICATIONS (dose and frequency):

ALLERGIES: NKDA or list medication & reaction

ALLERGY to LATEX, iodine, tape, food, environmental (circle all that apply) details: _____

REVIEW OF SYSTEMS (Check normal or all that currently apply):

GENERAL <input type="checkbox"/> NORMAL <input type="checkbox"/> Abnormal weight loss <input type="checkbox"/> Abnormal weight gain <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Chills/Sweats <input type="checkbox"/> OTHER:	HEENT <input type="checkbox"/> NORMAL <input type="checkbox"/> Headache <input type="checkbox"/> Blurred vision <input type="checkbox"/> Tinnitus <input type="checkbox"/> Dizziness <input type="checkbox"/> Epistaxis <input type="checkbox"/> OTHER:	CV <input type="checkbox"/> NORMAL <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Murmur <input type="checkbox"/> PND/orthopnea <input type="checkbox"/> LE swelling <input type="checkbox"/> OTHER:	PULMONARY <input type="checkbox"/> NORMAL <input type="checkbox"/> Wheezing <input type="checkbox"/> Cough <input type="checkbox"/> SOB <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Sputum <input type="checkbox"/> OTHER:	GYN/URO <input type="checkbox"/> NORMAL <input type="checkbox"/> Dysuria <input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Hematuria <input type="checkbox"/> Pelvic pain <input type="checkbox"/> OTHER:
NEURO <input type="checkbox"/> NORMAL <input type="checkbox"/> Migraine <input type="checkbox"/> Seizure <input type="checkbox"/> TIA / Stroke <input type="checkbox"/> Weakness / syncope <input type="checkbox"/> Sensory impairment <input type="checkbox"/> OTHER:	GI <input type="checkbox"/> NORMAL <input type="checkbox"/> GERD <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Diarrhea/Constipation <input type="checkbox"/> Bowel habit changes <input type="checkbox"/> Melena <input type="checkbox"/> OTHER:	MS <input type="checkbox"/> NORMAL <input type="checkbox"/> Joint swelling/pain <input type="checkbox"/> Limitations/neck mobility <input type="checkbox"/> Gait difficulty <input type="checkbox"/> Deformity <input type="checkbox"/> Prosthetic devices <input type="checkbox"/> OTHER:	ENDOCRINE <input type="checkbox"/> NORMAL <input type="checkbox"/> Hair loss <input type="checkbox"/> Excessive sweat <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance <input type="checkbox"/> OTHER:	HEME/LYMPH <input type="checkbox"/> NORMAL <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> DVT history <input type="checkbox"/> Enlarged nodes <input type="checkbox"/> Immunosuppression <input type="checkbox"/> Recent steroid use <input type="checkbox"/> OTHER:

Details for Pertinent Positives: _____





UConn Health
 John Dempsey Hospital
 Farmington Surgery Center
 Preadmission Evaluation Center

(Patient Identification)

Pre-Op History and Physical Exam

PHYSICAL EXAM (do not leave blank):
 Ht: _____ Wt: _____ BMI: _____ BP: _____ / _____ HR: _____ RR: _____ Temp: _____

General: _____ HEENT: _____
 Heart: _____ Lungs: _____
 Abdomen: _____ Extremities: _____
 Neuro: _____ Other: _____

PAIN ASSESSMENT: acute or chronic location: _____
 Description/exacerbating factors: _____
 Current pain score (scale 0-10): _____ Chronic opioid use: Yes No Pain contract: Yes No

FUNCTIONAL STATUS:
 LOW (<4 METS – can not walk > 2 blocks slowly, basic activities of daily living, light housework)
 MEDIUM (4-10 METS – climb 1 flight of stairs without pausing, run short distance)
 HIGH (>10 METS – strenuous sports)

IMPLANTABLE DEVICES (type/manufacturer/model): _____

PERTINENT LAB TESTS/DATA: _____

MEDICATION(S) PLAN: _____
ANTICOAGULATION PLAN: _____

RECOMMENDATIONS: Stable medical condition
 Pending labs/testing: _____
 Further evaluation recommended before procedure: _____

RISK STRATIFICATION ACC guidelines: cardiac risk low medium high

H&P Performed By:

_____ Signature / printed name	_____ Date	_____ Time
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Fax this form directly to the Preadmission Evaluation Center (PEC) 860-676-3427

Refer to Dept of Anesthesiology "Guidelines for the Pre-op Preparation of the Surgical Patient"

If a Preadmissions Consult is indicated, contact APRN beeper 860-588-7948 / phone 860-679-6688

Day of Procedure Practitioner Attestation

I have examined the patient and the above information is accurate.
 I have examined the patient and the above information is revised as follows:

_____ Signature / printed name	_____ Date	_____ Time
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